Camelot Care (Somerset) Limited

Acacia Nursing Home

Inspection report

166 Hendford Hill
Yeovil
Somerset
BA20 2RG

Tel: 01935470400

Date of inspection visit:
14 February 2018
15 February 2018
19 February 2018

Date of publication:
11 January 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced inspection of Acacia Nursing Home on 14, 15 and 19 February 2018. The first day of the inspection was unannounced. This inspection was undertaken in response to concerns we had received from staff members, relatives and external healthcare professionals who visited the service. The concerns primarily related to the management of medicines, people receiving safe care and treatment, staffing and leadership and governance.

When Acacia Nursing Home was last inspected in June 2017, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We identified the provider had failed to ensure that all risks had been mitigated to people living at the service because records had not been accurately maintained. In addition, we found the provider had not fully implemented effective systems to monitor the quality of care people received. Legal notifications had not been received by the Care Quality Commission as required.

The provider wrote to us following this inspection in August 2017 to tell us the actions they would undertake to achieve compliance with the regulations. During this inspection, we found the provider had failed to undertake these actions. In addition to this, we found additional breaches to the Health and Social Care Act 2008.

Acacia Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is able to accommodate up to 39 people. At the start of the inspection there were 35 people living at the home and one person was in hospital. The building is purpose built and has a courtyard garden in the middle. There are three floors with communal spaces such as lounges and dining rooms on each floor. At this inspection everyone had their own individual bedroom.

There was no registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection recruitment was being undertaken to employ a new registered manager. Whilst they were doing this one of the directors, a qualified nurse, was acting manager. They were supported by a deputy manager and nurses. During January 2018 there had been a manager in post recruited by the provider to be the registered manager. They had resigned prior to this inspection.

The home was not well led and shortfalls identified during this inspection had not been identified by the directors. There was a disorganised approach from management and lack of systems in place to audit the service people were receiving. The provider had not completed all statutory notifications in line with legislation to inform external agencies of significant events. The provider was not clearly displaying their

current inspection rating for the service as required. Many documents could not be found or did not exist at the time of the inspection.

People were not safe at the home because people did not receive care and treatment in line with their health needs. There were risks of infections spreading because the management did not have clear systems in place to manage infections. Some risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. However, not all risks had been identified and those that did lacked guidance for staff to follow. Medicines were not managed safely.

People who required special diets and drink did not always have their needs met and when people were eating in communal areas meal times were not always treated as a social opportunity. Staff had not always received training to have the skills and knowledge required to effectively support people. People told us their healthcare needs were met and staff supported them to see other health professionals.

People were not always protected from potential abuse. Staff understood how to recognise signs of abuse and knew who to report it to. However, there were times action had not always been taken or in a timely manner. The recruitment procedures in place had not always been followed to protect people from unsuitable staff supporting them. There were not enough staff to meet people's needs consistently and keep them safe.

Staff had developed positive relationships with people. There were mixed opinions about whether people liked living at the home. People's privacy and dignity had not always been respected and staff did not always offer choice to them.

Activity coordinators liaised with people about the activities they would like. However, there were times people's personal interests had not been considered. There were mixed opinions about whether complaints were investigated and responded to in a timely manner.

Most people and their relatives told us, that staff were kind and patient. People's care plans were sometimes generic and lacked personalised details to help guide staff to their needs and wishes. People were not always supported to have all areas of their life considered prior to their death.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. Three of these breaches were repeated from the previous inspection in June 2017. You can see the end of the report for the actions we took.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement

action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely and people were not consistently receiving safe care and treatment.

People were put at risk because their current care plans lacked guidance for staff and risk assessments had not always identified actions to mitigate known risks.

People were not always protected from the risks associated with poor staff recruitment because the procedure was not always followed for new staff.

People had risks of abuse or harm minimised because staff understood the correct processes to be followed. Improvements were needed with how allegations were managed

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had the skills and knowledge to meet their needs.

People who lacked mental capacity did not always have decisions made in line with current legislation.

People were at risk of receiving food not in line with their preferences.

People had access to medical and community healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

People's preference for the gender of staff to support them with intimate care was not always respected. Sometimes decisions were made by staff without consulting people.

People's privacy and dignity was not always respected by staff.

People's needs were met by staff who were kind and caring. Improvements were required because staff were task orientated.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs and wishes regarding their care was not always understood and care plans lacked important information to provide guidance for staff.

People benefitted because staff made efforts to engage with people throughout the day. Activities were not always in place in accordance with people's interests.

People knew how to raise concerns. However, complaints had not always been managed in line with the provider's policies.

People did not always have a dignified death planned with them.

Is the service well-led?

Inadequate

The service was not well led.

People were not living in a home which had clear external scrutiny to ensure they were receiving care and treatment in line with their needs. There were no clear systems identifying shortfalls found during the inspection.

People and their relatives were not always kept informed by the provider about recent inspections because the home did not display their current ratings clearly.

People's care and safety was compromised because other agencies were not being sent information in line with the provider's statutory responsibilities.

People benefitted from living in a home where there was a staffing structure to provide lines of accountability.

Acacia Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out by two adult social care inspectors, a medicine inspector, a nurse specialist adviser, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This inspection was undertaken in response to concerns we had received from staff members, relatives and external healthcare professionals who visited the service. The concerns primarily related to the management of medicines, people receiving safe care and treatment, staffing and leadership and governance.

When Acacia Nursing Home was last inspected in June 2017, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

As this inspection was brought forward following concerns received the provider had not completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information that we had about the service including the information of concern we had received that triggered the inspection, the provider's action plan, safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 18 people who used the service and seven people's relatives or visitors. Following the inspection one relative spoke with us on the telephone. We also spoke with 21 members of staff. This included two directors, the deputy

manager, nursing staff, care staff and ancillary staff.

During the inspection, we looked at 12 people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to food and fluid consumption. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

During the inspection we asked for 18 documents to be sent to us which we were unable to find at the home. These were not sent within the deadline. The directors told us they had technology issues. Following the inspection we asked for a further eight documents and these were sent within the time frame requested.

Inadequate

Is the service safe?

Our findings

At our inspection in June 2017, we identified that records relating to possible risks to people were not consistently completed to ensure these were accurately monitored and mitigated. People were not always protected from accidents and incidents being repeated because there was a mixed approach to how the management responded to accidents and incidents. We found some examples where risk had not been fully assessed in relation to pressure ulcer care and nutrition. We also found examples of identified risks which had not been reviewed in a timely manner.

The provider wrote to us following the inspection in June 2017 to tell us how they would achieve compliance with these regulations. During this inspection, we found that insufficient action had been taken and the service remained in breach of the regulations. In addition we found concerns in relation to the management of medicines, pressure care issues, risks of people choking and staffing.

People were not kept safe if they had recently moved into the home. One person moved into the home a week before the inspection; a previous placement had identified the person was at risk of pressure ulcer; this was documented in other agencies assessments prior located in their care plan. No members of staff, including one of the directors, knew about this risk. There was no printed care plan in place to provide guidance for staff about how to reduce the risks of an ulcer developing. Other agencies assessments also identified the person had risks around mobility. One member of staff found an electronic care plan and this still contained no guidance or record of the mobility issues, neither did it contain guidance about how to mitigate the risks of pressure ulcers. This meant staff did not have sufficient information to keep this person safe and meet their care and health needs.

People were at risk of significant harm from pressure related wounds. Two people had already developed them in the home. Five out of nine special air mattresses we checked were incorrectly set. Despite informing the home of this on the second day of the inspection, by the third day four were still incorrectly set. This meant people were not having pressure spread equally to reduce the likelihood of pressure related wounds. No people's care plans contained clear guidance for staff about how the mattresses should be set and when they should be checked. During the inspection the directors made a list of all the mattresses and told us they would add a sticker to each mattress. They did not appear to understand the importance of care plans containing detailed guidance for staff to follow to reduce the risk.

One person had an air mattress with an alarm sounding to indicate a potential fault. Staff had turned it to silent and taken no action to find out why the alarm was sounding. The person said, "It is like sleeping on nuts and bolts" and complained parts of their body were sore. One of the directors told us the pain could be related to another condition the person had. They told us they would find out if the person would like additional pain relief and staff would review the air mattress.

People's records did not always provide clear guidance to staff about how often they should be repositioned to prevent pressure sores. One person had a care plan which instructed they should be repositioned two to three hourly in one section and in another place within the care plan it stated every two hours. Their records

did not show repositioning had been completed every two or three hours for five days in February 2018. Nor was there any instruction to prevent their feet being on top of each other. They had developed a pressure sore on their foot. Special equipment to reduce the likelihood of this was not used until the last day of inspection. One of the nurses was going to update the person's care plan to ensure all staff were aware of the special equipment and repositioning. During the inspection we liaised with the local authority safeguarding team to share our concerns around pressure care. Following the inspection they visited to monitor whether people were receiving safe care and treatment.

When people had difficulty swallowing, referrals had been made to speech and language therapists to identify if their food and drink needed changing. One person required a special diet and this was seen provided during the inspection. However, some people were at risk of choking or aspiration in the home because they had swallowing difficulties and required thickened drinks. Three out of five people with special instructions from a speech and language therapist had their drink prepared incorrectly with thickener. All five had no clear guidance in their care plans to inform staff how to keep them safe and prevent choking. As there was a high use of agency staff it was important clear instructions were present to prevent errors and placing the person at risk of harm. Following the inspection we shared our concerns with the local authority to keep people safe from harm. They have visited to ensure people were receiving safe care and treatment.

People were not receiving their medicines safely. One person said, "They bring them round when they're due. Sometimes they get mixed up with the times. I think people should do it who know what they're doing. It shouldn't be agency staff". Gaps were found in seven out of 13 medicine administration records (MARs). It was not clear if medicines had been administered or had not been recorded. We found some medicines were not being administered as they had been prescribed. Some medicines had not been administered at all without a reason recorded. This was brought to the attention of the staff and we were told these errors would be investigated.

Handwritten additions to MARs had been dated and signed but had not been double checked by a second member of staff. This meant there was a risk of entries being incorrectly written and therefore people may not be receiving the correct quantity of their medicine. There was one chart with a discrepancy in the strength of a medicine recorded to that described. Despite us raising the concerns on the first day, one person's handwritten MARs later in the inspection still contained only one staff's signature. This meant it had not been checked by a second competent person. People who were prescribed medicine patches or insulin had separate recording charts but all four that we saw had gaps in the recording. This meant there was a risk they could have missed their medicine.

Suitable records had been kept for the ordering and disposal of medicines. One person had not been administered their medicines for the last three days as they did not have the medicines in stock. This had been identified by the home and they had been in touch with the GP surgery and the supplying pharmacy. However, it had only been followed up when the person had already run out of their medicines. This meant they were at risk of harm because they were not receiving their medicines.

There were suitable arrangements for storing medicines which required extra security. Regular checks of these were made and no issues were identified. However, not all medicines were stored securely. During the medicines round the medicine trolley was left unattended and there were some medicines left on top of it unsecure. When this was brought to their attention the staff locked these medicines away. Some medicines were stored in an unlocked cupboard in the treatment room. The treatment room was accessible to all staff in the home so there was no assurance that access to medicines was restricted to appropriate staff.

Medicines were not always stored in conditions as advised by the manufacturers. Two bottles of eye drops

requiring cold storage were stored at room temperature. This meant the medicine may have been damaged and could harm the person. Records of daily fridge and room temperatures showed the temperature was regularly being recorded higher than the recommended range. It was not clear if staff were resetting the thermometer after each occasion and there was no evidence that the raised temperatures had been investigated so medicines may not be safe or effective. We spoke with one of the directors who appeared to struggle to understand why it was important to monitor the temperature range.

Opening dates were being recorded on most liquids and eye drops. However, three bottles of eye drops, which were currently being administered did not have this recorded. Staff told us they had no assurance that they had not expired. They disposed of the bottles and new ones were opened.

Staff had additional guidance for medicines prescribed to be taken 'when required' and they explained when medicines could be given. However, some lacked detail on when the medicine should be administered. We also saw a number of these 'when required' protocols missing from records. This meant staff may not give doses of medicines as intended by the prescriber.

Some people were receiving covert medicines (medicines given without their knowledge). Records showed that their mental capacity had been assessed and their best interests had been taken into account with a GP and family members. However, pharmaceutical advice had not been sought on the best way to administer these medicines safely. This had been raised with the provider at the previous inspection and remained a concern.

People were at risk of becoming ill because the spread of infection was not managed safely. One person told us staff were returning to work after being absent and then shortly after becoming ill again. One of the directors told us they had been liaising with Public Health England (PHE) due to an outbreak of vomiting and diarrhoea. We were informed people were being looked after in their bedrooms to prevent infections spreading. However, the director was unable to provide accurate numbers of people affected until we had asked numerous times. Seven people were identified with either diarrhoea or vomiting throughout February 2018. No samples had been sent off to identify the cause. During the inspection, staff collected the first sample from a person. People were still seen in communal areas on each floor. Hoist and slings had not been isolated for one person who was being barrier nursed in their bedroom which meant it risked spreading the infection. During the inspection an Environmental Health Officer visited the home to follow up concerns they had received from PHE. They completed an additional visit during the inspection to ensure adequate deep cleaning was occurring at the home to reduce the spread of infection. Following the inspection the provider informed us they had sent two staff home again after returning to work too early because they were still unwell.

Housekeeping staff told us they had been asked to deep clean throughout the home for the previous two weeks. Every room had a daily superficial clean and there were records on bedroom doors. However, systems were not clearly documenting how the cleaning was being undertaken. Records recorded both 'deep cleaning' and 'spring cleaning' with no explanation to the difference. Following the inspection the provider informed us deep cleaning was more intense and a steam cleaning machine was used. One member of care staff tried to clear up a spill with a dry mop because they were unable to find a member of the housekeeping staff. This meant when they did arrive they were unsure why the floor needed cleaning. So were unable to make sure the floor was safe and clean for the people using the service.

All mops were colour coded so different areas of the home were cleaned with different mops to reduce the spread of infection. A red mop was used to clean up a communal lounge and dining area. According to a poster in the home the red mops should be for bathrooms and toilet areas. One member of staff confirmed

this was the case. They also told us they did not have yellow mops which should be used when there was an infection in a person's bedroom. By not having effective cleaning systems in the home there was an increased chance infections could spread.

People who could display behaviours which challenged others did not have clear guidance to instruct staff how to support them safely. One person had been involved in an alleged incident towards another person. Their care plan had not been updated until it was identified during the inspection. Following the update in the care plan it was clear the person was meant to be monitored every 15 minutes by staff. Numerous instances occurred where they were seen without staff being aware. For example, for over 30 minutes they were alone in a communal space having spilt food and drink on the floor. They had been walking through the spilt drink getting wet slippers. Four staff had not recognised the person's slippers were covered in milk for over an hour. A member of the inspection team informed staff so they could prevent them from slipping over and change the wet slippers. One of the directors told us they should be regularly monitored and they would follow this up. On the third day of inspection a staff member was asked where the person was and they did not know. They searched the entire floor and asked another person whilst looking for them. Records of the monitoring did not match what inspectors had seen.

Most people had a personal emergency evacuation plan [PEEP's]. These detailed which room the person lived in and the support the person required in the event of a fire. However the folder was on a bookcase in the office and not with the emergency grab bag. Information in the folder had not been updated since September 2017. This meant people's needs may have changed and their mobility deteriorated. It also meant that some people had moved rooms, left the home or passed away. The out of date folder meant both the lives of people living in the home and of those assisting an evacuation were put at risk. Two people had recently moved into the home and did not have personal evacuation plans. One of the directors told us they had moved the personal evacuation plan file from the 'grab bag' so they could update it. During the inspection the providers and staff updated the file to reflect the current people living in the home and placed it near the emergency grab bag. Following the inspection we contacted the fire service and raised our concerns.

People were not always kept safe because accidents and incidents were not always followed up and lessons had not been learnt. One person had fallen and hit their head. No actions had been recorded following the accident and it did not say they had received any monitoring or treatment. We spoke with one of the directors who was unaware of the accident. They told us they would follow this up. This meant the management were not ensuring appropriate actions had been taken to keep people safe. Another person had a fall in October 2017. Their care plan still said, "[Name of person] has a history of falls, but since she has been at Acacia she has not had any falls". This had been reviewed three times by members of staff since October 2017 and no changes had been made to the care plan nor had anyone identified lessons learnt from the fall. This meant the person was at risk of further falls because there was no guidance for staff.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there were not always enough staff to meet people's needs at key times of the day. During this inspection, we found people were still not supported by enough staff to keep them safe and meet their needs. Throughout meal times there were more people who required individual support than staff available to support them. For example, one member of staff had to support three people to eat their meals and this took over half an hour. On other floors there were similar issues with lots of people who required support and not enough staff at meal times. One member of staff said, "On the middle floor we support eight with eating and just three staff. Tea time takes longer as some like to go to bed earlier and that

takes one off the floor".

People and relatives had mixed views about whether there were enough staff. Some people explained their call bells were answered whilst others felt it took a long time. One person said, "They're rushing all the time. I try to keep my head down". Other people told us, "When we're fully staffed it's good", "They look after you OK. Nine times out of ten [they respond to the bell] but sometimes they are short" and, "They're very pushed sometimes, but if you need them they're there". One relative said, "Staff are rushed off their feet". The relativeexplained a scenario where they had been left in a lounge with 10 people alone who were at risk of falls if they got up unsupported. During the inspection there were times call bells did ring a lot. Staff had mixed views of if there were enough staff. Some staff said, "It's got better - we were always short of staff but now [provider's name] has got her own agency and she can use them" and, "Yes we have enough staff. Some days are better than others. It's just when someone goes off sick you feel it". Whilst other staff told us, "I don't always get the chance to read the care plans - rushed off my feet", "We could do with another qualified [meaning nurse], mentioned it [to the provider] but nothing happened" and, "Sometimes can be difficult when short and agency don't know the residents. Lot of staff have left since I started".

One of the directors told us there were always two nurses on duty to complete the medicine round and support people with clinical issues. Only one nurse was on shift and a senior staff member completed the medicine round each day of the inspection. The staff member had received administering medicine training. The senior member of staff was not a nurse and was also helping run the agency being run from the home. The rota showed there were other days when only one nurse was on shift, especially at weekends. Following the inspection the local authority made a request to the provider there must be at least two nurses on every day shift to keep people safe.

During the inspection further staff were brought in to work which were not on the rotas. The directors informed us this was to make sure people had their needs met whilst staff looked for documents and supported the inspection team. The provider gave the inspector two different versions of a dependency tool for 2017. This was how they determined how many staff were required to support people in the home. The first version of the tool had higher numbers of staff required in seven out of 12 months. This meant systems to identify staff levels to keep people safe and meet their needs was not consistently being used.

This was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's procedure for recruiting staff did not always safeguard people from the risk of abuse. The provider always carried out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. However they did not always obtain character references from previous employers. For example one staff member who did not have a previous employer had two references from friends. The provider had not contacted their educational facility to obtain a character reference from a tutor who had known them for a significant time. Another staff member had a reference from a friend who worked within the home. They had given the name of a previous employer but they had been there such a short time they were unable to give a reference. Another person they had previously worked with only knew them on a self- employed basis for 15 days. This meant people were being supported by staff where the provider had not checked for good character.

People and relatives thought they were kept safe from potential abuse. One person told us, "I haven't had any problems. There's always someone around to help me". Another person said, "I do [feel safe] during the week". One relative said, "I think so" when asked if people were safe. Another relative explained there had been an incident which was managed quickly. Staff understood how to recognise signs of abuse and keep

people safe. Most staff felt if they raised a concern to the management it would be followed up. However, people were not always kept safe when there were allegations of potential abuse reported. Prior to the inspection we were informed about an alleged incident involving agency staff. One of the directors told us nothing had been put in writing to her. They had not investigated the allegation because it could have been related to historical arguments between staff in the home. The director then told us another senior member of staff had followed this up and found the allegations to be false. Prior to the inspection there had been two retrospective notifications of abuse sent to us by the manager who started in January 2018. This meant there was an inconsistent approach by the management about how concerns were managed and investigated to keep people safe.

Regular checks were carried out on equipment used in the home such as hoists and wheelchairs. The call bell system was tested regularly to ensure people were able to call for assistance. Fire alarms, emergency lighting, door closures and firefighting equipment were checked in line with current guidance. We looked at the records for staff fire drills. The staff member responsible for the records was unable to find a copy. On the third day of our inspection we were shown a copy of the last two fire drills carried out and one was dated the second day of inspection. We asked if they had sounded the alarm as we were in the home inspecting that day and the alarm did not sound. The provider apologised and said they had got the date wrong and it was meant to say a date between the second and third days of inspection. Night staff had not had a fire drill since at least June 2017. This meant people were at risk of being supported by staff who did not know the correct procedures to follow in the event of a fire. Following the inspection we raised our concerns with the fire service.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At our previous inspection in June 2017, we found some people who lacked capacity had not always had decisions made on their behalf following the principles of the MCA. Some documentation was historical and had been completed by the previous provider who owned the service. We also found that where people had been assessed as lacking capacity, best interest decisions were not consistently made in line with legislation. We made a recommendation that the provider reviewed national guidance relating to the MCA and updated their current practice accordingly. During this inspection we found there had been a small amount of improvement for some people. For example, one person chose to lock their bedroom door at night and had dementia. Due to their memory declining and for safety reasons a capacity assessment had been completed followed by a best interest decision. And the outcome was to be reminded every night by staff they could lock their door.

However, further concerns were found because one person had a pressure mat in their room. When we had asked at the beginning of the inspection who had restrictive practices in place this person was not named. We asked to see a copy of their care plan. Not one staff member was able to find the care plan. We reminded staff we wanted to view the care plan several times throughout the day. On the third day of the inspection we were given a best interest decision for the use of the pressure mat. The best interest decision was dated two days after we had requested the care plan and observed a restrictive practice in place. Other people did not always have records of who was consulted during the decisions. This meant people were at risk of decisions not being made in line with MCA legislation.

People were not always supported by staff who had received training in subjects relevant to their care and health needs. Staff spoken with said they received regular updates in the organisations mandatory training. However, they also said the training only consisted of watching digital versatile discs (DVD's), one staff member said, "It's alright if English is your first language but nobody checks how much staff understood if it isn't". This meant there was a risk that staff with English as a second language did not understand the training being delivered.

We requested an up to date copy of the training matrix, this is a record of all training staff completed through the year. This showed one staff member had completed 19 training sessions using DVD's in one day. We asked the manager if they thought this was possible. They were not sure if it was possible for a member of staff could complete that many DVD's in one day. We looked at the running times of the 19 DVD's. To just watch them continuously the staff member would have needed 14.5 hours with no break in-between. This did not allow for the written checks of understanding they should complete following each DVD. Another staff member who had recently started to work at the home had carried out their induction in the same

manner on the one day. This meant the training for staff was not always effective in ensuring they were up to date with current practices.

Concerns found during this inspection highlighted staff appeared to lack knowledge and understanding on certain topics. People were placed at risk because their drinks had not been thickened in line with a health professional's assessment. Some people had developed pressure wounds at the home. This meant people were placed at risk because the training did not equip staff with the required knowledge to meet their care and health needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had been undertaking the Care Certificate. The Care Certificate is a nationally recognised standard to make sure all staff working in care have basic skills to look after people. However, one member of staff said they had received no practical assessments as part of this. This meant there was a risk the competency of the new staff was not being monitored in line with national standards.

People did not always have a positive experience during mealtimes and there was a risk they could receive cold food. One person told us their food was sometimes overcooked. Another person said, "It's not my type of food. I would like a fry up at least once a week". All the people we spoke with, without exception, were not enthusiastic about the food.

Although people who could eat solid food were offered the choices for lunch in the morning, the people requiring a pureed diet all had the same meal. When one person asked what it was, the staff member replied, "Mash and lamb, I think." Nobody was asked if it was what they had ordered. People were able to say if they did not want the food which was served and alternatives were found. One person did not want their lunch so had cheese on toast instead. Another person declined the pudding and chose a yoghurt instead. Staff members facilitated the different food choices immediately.

We observed one staff member take three covered dinner plates out the dumb waiter. They did not put them on a tray to display them nicely. They obtained the cutlery and went to the first room. The staff member placed the three plates on a person's table and proceeded to assist that person to eat. Twenty five minutes later the staff member moved onto the next person taking two plates into that person's room and again placing them on the table. A second staff member collected one of the plates of food and took to the third person. This meant the last person's food had been out of the dumb waiter that was keeping it warm for 30 minutes before they were assisted to eat. This not only meant people were given cold food but the food was also at risk of contamination from being in other people's rooms. When the dessert arrived they were all removed from the dumb waiter and placed on a table. They were uncovered and stayed there until they were all handed out or people were assisted to eat. This also meant the food was at risk of contamination. As the home had been experiencing stomach infections and flu related infections this was poor practice. It also meant that people were not being treated with the dignity of enjoying a social occasion at lunchtime.

People who had recently moved into the home had not been assessed fully prior to moving into the home to identify any needs and wishes they had. Some people had clear assessments which identified their health and care needs. Care plans had been written to reflect some of these needs in various amounts of detail. However, one person had recently moved into the home and the director told us they had consulted with relatives as part of the assessment. Their care plan had little record of the assessment. One of their relatives did say they spent some time with one of the directors prior to their family member moving in. This meant

there was a risk the person's immediate health and care needs would not be met. During the inspection we found this was the case in relation to pressure care and mobility.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made applications for some people to be deprived of their liberty to keep them safe. People's care plans demonstrated there had been DoLS requests made when they lacked capacity and were under constant supervision.

People were able to personalise their bedrooms when they moved into the home. One relative told us they had brought a television because their family member liked watching it. They also brought pictures of the person's family so they could reminisce and have conversations about them. During our discussions the person started to smile when we were talking about pictures from their previous employment. Other people had pictures and personal belongings in their bedrooms.

People had access to other health and social care professionals. One person said, "I've just seen the doctor here". We saw visits from other health professionals during the inspection including a doctor and the district nurse. One person was in hospital during the inspection and another person had recently returned from hospital. Care plans demonstrated people had seen speech and language therapists when they had swallowing difficulties.

Requires Improvement

Is the service caring?

Our findings

Most people told us they were supported by kind and caring staff. We observed some very caring and kind interactions from staff. People said, "We're well looked after" and, "Most of the time it's very good. Today, it is very miserable as there is no one around. I can't go downstairs on my own. They're very nice people". One relative said, "The nurses were very nice. [Name of nurse] is very good". Another relative said, "All staff have been so pleasant" and continued to say, "They seem to be very caring". Two relatives thought their family members had improved since moving into the home due to the caring staff.

However, there was a task orientated approach to the way staff ran their shifts. One relative told us when they have been there early in the morning a member of staff had got their family member up even if they had been asleep. They said, "Why couldn't they leave him". On occasions, staff would walk into a room and not acknowledge the people there because they were focussed on something else. Other times the interactions with people was led by needing to support them with a task. There were occasions people were wheeled around in their armchairs without being informed the purpose and no conversation.

People were not always supported in a way which showed them dignity and respect. One person had been walking around and a member of staff identified they needed a shave. No other members of staff had identified this. Some people were seen walking around the home with dried food on their clothes. This meant people were not having their dignity maintained when they were no longer able to look after themselves. People were not respected at meal times with cold food being served to people who needed help to eat. This was as a result of the staffing level provision and not reflective of staff efforts.

There were different approaches to the type of crockery people used on the ground floor and the middle floor which was the floor where people living with dementia lived. People on the ground floor had white china crockery. The people on the middle floor had plastic crockery throughout. This gave the feeling that people were not being treated with dignity and respect due to the lack of understanding around living with dementia. We did observe that the plates were coloured which evidenced good practices for enabling people living with dementia to identify the food on their plates.

People's privacy was not always respected. One person had entered another person's bedroom whilst they were in the en-suite bathroom being supported by a staff member. The staff member did not ask the other person to leave or close the bathroom door. One of the directors told us the person was no longer being supported with intimate care. Following the inspection the provider told us the member of staff had prioritised the person's needs and did not close the door because they were about to leave the bathroom. Throughout the inspection we observed staff left people's personal care files in communal spaces without a member of staff in attendance. This meant people's personal details were not being stored safely and placed them at risk of being read by someone else. We also saw a piece of paper on the dining room wall on the middle floor which said, "Oral nutritional supplements. [Person's name] Fresubin, juicy apple once daily, (afternoon tea)." This could be read by anyone in the room. This meant the person's personal information was not kept confidential.

When people were offered choice staff respected it. However, there were times when people were not consulted. For example, the music played around the home was solemn music and no people had been asked if it was their preference. In some rooms the music was so loud people sitting next to each other struggled to speak. One person was concerned they were not offered choice about the gender of staff who supported them. They said, "A young man was left to do [intimate care]. He's alright but I think it's better to be a woman for something like that. But the choice isn't always available. You have to have whose there at the time". This meant people's preferences for intimate care was not always respected and care delivered in line with their preferences. .

The previous manager had recorded some compliments the home had received. These included a health professional complementing staff being, "Welcoming, pleasant and communicative". Another care professional complemented them on how informative a person's care plan was they reviewed. One relative wanted to say thank you for all the care their family member received and how, "Kind and caring" staff were. There had been no compliments recorded since the last inspection apart from in January 2018. Following the inspection the provider sent us another compliment received from a relative. It thanked them for the card they sent and commented on the care and entertainment available at the home.

Requires Improvement

Is the service responsive?

Our findings

Most people had an individual care plan which gave basic information about how they liked to be assisted. There were occasions during the inspection people's care plans could not be located immediately when we requested them. One director explained they were transferring between paper care plans and electronic care plans. They told us that despite attending training three times for this they were still unfamiliar with the system. They were also responsible for training the staff at the service in the electronic system.

Some people's care plans contained information which highlighted their needs and wishes. They informed staff about the support they required and gave details of important things to them. For example, one person's care plan informed staff to look at their photo albums with them. Another person's care plan contained some information about how to support them at specific times of the day. However, one person had recently moved in and had an incomplete care plan. There was no guidance for staff how to support them with intimate care nor how to respond to their dietary preferences. Additionally, it had been assessed they required support with intimate care. Again, there was no information for staff to follow in relation to this about how they should support them. During the inspection an electronic care plan was provided which was incomplete. For example, there was a completed assessment stating they had chronic pain yet no guidance for staff to follow about supporting this. This meant there was little guidance to inform staff of their needs and wishes.

On other occasions people's care plans did not contain enough information to inform staff because they had generic statements. For example, one person had a health condition with no details about how this could impact on their lives and the support required from staff. Although some staff we spoke with during the inspection knew people, the home also used agency staff who may not have knowledge of people's preferences or needs. Another person could suffer, "Dizzy spells" yet there was no information about what this meant and what signs staff should monitor them for. This meant they were at risk of not receiving care in line with their needs.

People did not always have their care plan updated when their needs changed. One relative told us the needs of their family member had changed and they did not think the daily care plan reflected this. One person had been involved in an incident with another person. Only one of the people's care plan had been updated to provide guidance for staff to follow. By the final day of inspection the second person's care plan had been updated. Other people had deterioration in their health and their care plans had not been changed to reflect this. For example, one person had a decision made by family and health professionals in their best interest. The care plan contained no information about this. This meant there was a risk people's needs and wishes may not be respected and followed by staff. One of the directors told us record keeping was unsatisfactory on the new electronic care plans so they were going back to paper versions or finding an alternative electronic care plan system.

People were not always supported to have a dignified death. Some people had treatment escalation plans which outlined plans for if a person's health deteriorated. It included their wishes and needs should this happen. However, some people's care plans did not contain information about their needs and wishes for

the end of their life. Care plans focussed on people's death rather than their aspirations or final wishes. By not having this information staff would not know if there was anything important to the person to support them prior to their death.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives had mixed opinions about how complaints and concerns were managed. Two relatives told us they had raised concerns and these had been resolved. Another relative said, "I don't think she [meaning one of the directors] likes complaints" and continued complaints did not always get heard fully. The directors had set up systems to handle complaints from people or relatives they had a difficult relationship with. One director informed us this was so they knew every concern had been followed up. There had been a mixed approach as to how complaints had been approached depending on who had been managing the home. This inconsistency reflected the feedback we received during the inspection.

There were two activity coordinators in the home. One was an apprentice completing a course at college. During the inspection there was an outbreak of diarrhoea and vomiting. As a result, group activities had to be cancelled to prevent the spread of infection. On some of the days the activity coordinators were not at the home because of illness. When they were in they tried to visit each person in their bedroom. As a result, we were limited in how many activities we saw people participating in at the home.

People had mixed views about the activities. People said, "They try hard with activities and to entertain the residents" and the activity coordinators tried, "Very, very hard". Whilst another person told us about an interest they had and said no one talked with them about it. They said, "It would be nice to be able to talk about it in the home". Relatives commented on the fact that the staff responsible for activities were, "Good". One relative said their family member, "Does look forward to activities. The social interaction is good". They continued to tell us about minibus trips which occurred and at times, these could be affected by insufficient drivers or staff. Another relative told us, "The new entertainment person is good. She wants to get people over to the pub and have a meal" and added, "People want to go out". Other relatives said they, "Have been getting in singers. They have been doing things like that" and confirmed the activity coordinators have been going around the bedrooms.

Inadequate

Is the service well-led?

Our findings

At our inspection in June 2017, we found not all policies and procedures were being adhered to by the management in post which did not evidence good leadership. Medicines policies had not been followed in relation to seeking external pharmacist support when the need was identified. The quality assurance systems in place to monitor care and plan ongoing improvements had not always been effective in identifying concerns that may impact on the health, safety and welfare of people living at the service. In addition to this, the provider had not notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

The provider wrote to us following the inspection in June 2017 to tell us how they would achieve compliance with these regulations. During this inspection, we found that insufficient action had been taken and the service remained in breach of the regulations.

There was no registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection recruitment was being undertaken to employ a new registered manager.

Since the last inspection, in June 2017, one of the directors had been the acting manager except for one month. They were the controlling person for the provider. Therefore, there had been minimal external scrutiny. This meant there was a lack of assurance around the monitoring and sustainability of the home. Shortfalls found at this inspection had not been identified by either director. They had limited knowledge of the systems being used in the home and they had failed to meet the timescales in the action plan they had set. They told us the new manager had been instructed to complete the actions.The new manager had only been in post from January 2018, approximately four months since we had published the previous report.

Throughout the inspection we requested documents that should have been readily available. For example, on the first day of the inspection we asked for one person's care plan. Nobody was able to find it. We asked for this person's best interest decisions again on the second day of our inspection. When it was produced the document was dated after the date it was requested, evidencing it had been completed retrospectively following our request. Safeguarding records prior to January 2018 were asked for on the first day and were not received until the final day of inspection. Following the inspection the provider informed us they struggled to locate the safeguarding documents because the previous manager had archived them. There were also specific records relating to individuals unable to be found. For example, one person's records evidencing they could be given medicine hidden in food or drink. This had been raised at the previous inspection and one of the directors agreed to consult the pharmacist. By not having these records available it meant people's care, well-being and safety could have been compromised. Staff told us they felt the home lacked, "Organisation".

People were at risk of poor care because the directors were unfamiliar with their own systems to be able to

monitor them. There were accidents and incidents they were unaware of or could not locate the records for. Health and safety records prior to January 2018 were unavailable until later in the inspection. Following the inspection the provider informed us they had been having organisational difficulties which meant they were focussing on other areas of the home. On multiple occasions it had to be explained to the directors why people's air mattress settings were important to reduce the risk of pressure ulcers. This demonstrated a lack of understanding. One director was checking air mattresses around the home following concerns raised by the inspection team about them being incorrectly set and required it explaining again to them. People's mattresses were still incorrectly set on the third day of inspection reflected the safety issues.

Quality auditing had been inconsistently carried out which meant shortfalls had not been identified and resolved. For example, an internal medicines audit had been completed but there was no action plan to show how the issues raised would be managed. Medicines incidents and errors had been recorded. However, the records did not show what the results of an investigation were and what changes had been made following the incidents to ensure they did not reoccur. The incidents found on the day of the inspection were recorded and were being investigated. Other audits were completed during the inspection including a health and safety audit. This still failed to find shortfalls. For example, not everyone had an individual sling to use with the hoist. By not consistently having an auditing system people were placed at risk of poor health and care.

One of the directors, who was the acting manager and a qualified nurse, was unaware of clinical needs of the people living at the home. They were unable to provide us with an accurate number of people and staff who had become ill during the recent outbreak. They were also unable to tell us how many people had pressure related wounds and how severe they were. Nor were they aware who had specific dietary needs to prevent choking. They lacked a clinical understanding of concerns being raised during the inspection. For example, when medicine concerns were fed back on the first day they did not appear to understand how medicine fridge temperatures were monitored. Neither did they understand how medicine errors should be monitored. This meant people were at risk of receiving unsafe and poor care.

The provider was reporting things inconsistently to other organisations. This meant it was difficult for them to monitor people's wellbeing and safety. Public Health England (PHE) had been informed by one of the directors only four out of 41 people had been affected by the diarrhoea and vomiting outbreak; the home is currently registered to accommodate up to 39 people. Information provided during the inspection did not match what PHE had been informed. PHE were also unaware there had been further people and staff affected; they were informed all diarrhoea and vomiting had stopped at the home so declared it safe. During the inspection, we liaised with PHE so they had accurate numbers and appropriate guidance could be given to the provider.

We asked for copies of some of the home's policies and procedures. This included infection control, safeguarding adults, complaints and confidentiality. We found the policies had all been reviewed in September 2016. We asked if they were the most up to date policies and we were told they were. The policies reviewed directed staff to information which was out of date. They referred to the Care Quality Commission (CQC), National Minimum Standards for Care Homes for Older People quoting out of date regulations. The Infection Control Policy did not include any guidance on containing diarrhoea and vomiting outbreaks. It also contained guidance on needle stick injury which is out of date as the home should only be using safety needles for injections. This meant staff were being given inappropriate advice and could deliver unsafe care and treatment. During the inspection some of these policies were beginning to be reviewed.

Between the second and third days of the inspection the provider was requested to provide 18 documents or records which could not be found. These documents included records of water temperature checks,

safeguarding records prior to 2018 and record of fire drills. They were not received within the timeframe given. One of the directors told us they had computer problems. Most of the documents had been completed and dated during the inspection. The directors told us they had spent 16 hours each day of the weekend trying to produce the information we had requested. This information should have been in the home and readily available to view at the time of the inspection to ensure people were receiving safe care and support.

People were not being informed clearly about the most recent inspection at the home. There was a poster directly opposite the front door as you walked in the home. This contained old information and said the home had not been inspected. It also listed other care homes owned by the provider being good. The most recent ratings were displayed above eye level in the corner to the right of the front door which could easily be missed. We spoke with one of the directors who agreed the one clearly on display was old. By not clearly displaying the ratings the provider could mislead people and visitors to the home.

The directors told us they were trying to ensure people and their relatives could contribute to the running of the home. They had completed a quality survey in December 2017 to find out if there were areas of the home they could improve. However, the survey analysis said there were 31 respondents to the survey. Not one answer in the information given to us totalled 31. One answer was as low as eight and the highest was 21. No action plan was shared with us to demonstrate areas of improvement identified from the survey. Following the inspection the provider told us the reason no answers totalled 31 responses was because people had chosen not to answer all the questions.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications to other agencies had not always been made in line with current legislation to help them monitor people's safety and care. We had been notified about deaths of people at the home. However, several notifications had not been made in line with statutory requirements. For example, two safeguardings were sent retrospectively when the manager joined in January 2018. The directors were not aware of their responsibility to notify other agencies in line with statutory guidance. One director told us they were not aware a diarrhoea and vomiting outbreak was a notifiable incident because it could threaten the safe running of the service. Neither were they aware people with significant pressure sores needed to be notified; two were confirmed during the inspection. This meant there was a risk other agencies would be unable to monitor the care and safety of people living at the home. Following the inspection the provider informed us they were aware of when notifications should have been sent. They had requested a member of staff to send a safeguarding notification prior to them going on holiday.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009.

People and relatives had mixed views about the management of the home. One person was unclear who was currently managing the home. They said, "It's a bit hard trying to get hold of them [meaning the management]". Another person told us, "You have to be firm. If you want to see them [meaning the management]. You have to make a noise; but they're so busy". They thought the manager who started in January 2018 was, "Very good". All relatives were unaware there had been another change in management. They were complementary about the manager who had started in January 2018. One relative said, "It was a good home when I first went there". Other relative told us one of the directors was, "Compassionate and willing to listen to any issues", and, "Is always responsive and helpful". However, two relatives felt the management by the director was poor.

The directors had set up their own agency. They explained this was to ensure the quality of staff they were using. Many of the staff had previously worked for one of the provider's homes and so knew the systems being used. The plan was to role the use of the agency out across all of their homes to keep a standard of staffing in place. It meant they could ensure the training and competency of agency staff was a specific standard.

People were supported by staff who had lines of accountability. There was a supervision matrix to identify who should be supporting each staff member. Some staff had received supervisions. One member of staff told us they had not received regular supervisions or appraisals. They did complement senior staff and nurses for being very supportive. We asked what support and induction the new manager had received. One of the directors told us the manager's induction was not written down. It included information about the systems and operation of the home. They had been supervising them. None of the supervision records had been signed by the previous manager. We were told by one director they had given the supervision record to them and they never brought it back, but we were unable to confirm this.

Relatives meetings were held regularly but the one scheduled for the first day of inspection was cancelled. We were told by the director that this was because of the outbreak of infection. One member of staff told us it was because the manager was off. One relative explained this was the second time the relatives meeting had been cancelled and that relatives had only been informed at 11.15am the day of the inspection. Another relative was not happy about the short notice cancellation and felt that, "Once a date is fixed it should go ahead". They continued if a staff member is not available on the day then "There should be a back-up plan".

The directors had started to use online conversation applications to communicate with some relatives. They told us this helped to improve communication between them and made it quicker for them to share information. They explained it had been an effective form of communication for one relative who was currently using it.

The directors told us they were striving to improve the home and deliver high quality care for people. They held monthly meetings for the manager's at each of their homes. They told us the morning was to explore business matters and share information. The afternoon was to invite people to share good practice from other providers and homes in the area. For example, an owner of another provider which had achieved an outstanding rating was invited to share good practice with them. The hope was some of the systems used could be replicated in their homes.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission in line with their legal responsibilities.

The enforcement action we took:

We added conditions to the provider's registration. This was restricting admissions to the location and requiring the provider to send us a monthly report on improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care people received was personalised and met with their individual care needs and wishes. Regulations 9 (1)(a)(b) (3)

The enforcement action we took:

We added conditions to the provider's registration. This was restricting admissions to the location and requiring the provider to send us a monthly report on improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users. This is a breach of Regulation 12(1)(2)(a)(b)(e)(f)(g)(h)

The enforcement action we took:

We added conditions to the provider's registration. This was restricting admissions to the location and requiring the provider to send us a monthly report on improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people received

Diagnostic and screening procedures	safe, effective and responsive high quality care which was person centred and had not fully put in place systems to monitor the quality of care people received. Those which were in place had not operated effectively to ensure compliance. This is a breach of Regulation 17 (1) (2)(a)(b)(c)(e)(f)

The enforcement action we took:

We added conditions to the provider's registration. This was restricting admissions to the location and requiring the provider to send us a monthly report on improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. The provider had failed to ensure staff received appropriate support, training and supervision. This is a breach of Regulation 18 18(1) (2)(a)(b)

The enforcement action we took:

We added conditions to the provider's registration. This was restricting admissions to the location and requiring the provider to send us a monthly report on improvements they were making.